EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

FY10 BUDGET HEARING BEFORE THE JOINT COMMITTEE ON WAYS AND MEANS

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EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Thank you, Representative Fox and Senator Hart for hosting us today. I would also like to acknowledge Chairmen Murray and Panagiotakos, and the distinguished members of the House and Senate Ways and Means Committees.

In his state of the Commonwealth address in January, Governor Patrick noted the many successes of this Administration in the past year that have made Massachusetts a better place and also better prepared for tough times ahead.

Because of our partnership with the legislature:

- We have an increase in support for public education, a Life Sciences Bill and a Clean Energy package -- to grow jobs and shape a new economic and environmental future -- and funding and initiatives to end homelessness and move people from shelter to permanent housing.
- Health care reform has been sustained even in these challenging times. Not only do we have more than 440,000 newly insured in Massachusetts, but we now know that about 98% of everyone in the state has insurance and our best estimates suggest that every child in the Commonwealth is covered. As a result, 90% of people in Massachusetts now have a regular health care provider. This is even true for some of the hardest to reach populations. The percent of Hispanics who report having a regular health care provider has increased from 66% to 74%.
- In December, we announced that Massachusetts finalized a highly-favorable agreement with the federal government to renew the state's Medicaid waiver for 3 years bringing more than $21 billion to Massachusetts and about $4.3 billion more than the last 3-year period. This agreement means the Commonwealth will be able to continue our highly successful health reform model and that we will continue to provide health care coverage to individuals who had previously been uninsured.
- Health Care Reform has had a real impact on health. The U.S. Centers for Disease Control and Prevention released a report showing that Massachusetts had the fourth-lowest adult smoking rate in the nation in 2007. The 2007 rate, showing that 16.4% of adults smoke in Massachusetts, is the lowest rate ever recorded. We believe this is in part due to health care reform and people's access to providers who counseled them to stop smoking.

But we know that there is a lot of work to do and we have challenges ahead because of the devastating effect of bad policies on this state's and the nation's economy.

In October, as part of Governor Patrick's Emergency Recovery Plan, we made $1.4 billion in budget cuts across state government, including within Health and Human Services. While these cuts were difficult and painful, we made them

following a key set of principles focused on protecting the most vulnerable in our state.

Since October the economy has continued to decline. Tens of thousands of people in Massachusetts have lost their jobs. Houses, disproportionately in communities of color, are in foreclosure proceedings or have been foreclosed. Achievement gaps in the schools persist in poor communities. And, Black men are killing other Black men at ever more alarming rates.

But from crisis comes opportunity.

Federal Stimulus
At the federal level, we have worked hard to help shape the federal stimulus package to bridge us to a better economy.

The American Recovery and Reinvestment Act includes a number of provisions that will provide critical fiscal relief to the Commonwealth and to Heath and Human Services.

We are still assessing the fiscal impact and opportunities for EOHHS as a result of the federal stimulus package, but we tentatively expect to see relief in the following areas:

- Enhanced federal reimbursement for Medicaid (FMAP increase);
- Enhanced federal reimbursement for Title IV-E (Department of Children and Family services);
- WIC funding and Immunizations for the Department of Public Health;
- Senior Nutrition funding for Elder Affairs;
- Supplemental Nutritional Assistance Program (Food Stamps) and Emergency Assistance funding for the Department of Transitional Assistance; and
- Vocational Rehabilitation services funding for the Massachusetts Rehabilitation Commission.

In addition, the American Recovery and Reinvestment Act makes available considerable funding, primarily on a competitive grant basis, for Electronic Health Records and other e-health initiatives, available to state agencies, health care providers and institutions of higher education.

These resources will help avert continuing deep cuts, but we will not be out of the woods even after the stimulus package. That's why the Governor has ensured that we are not just standing still waiting for the federal government to solve our problems.

The Governor has filed a balanced budget proposal for the coming fiscal year. Given the decline in state revenue, spending must be at levels significantly below

what they have been in better times.

Over this and the next fiscal year, we will continue to work on many priorities in spite of the economic challenges. This crisis presents us with opportunities.

We all know that state government is not perfect and that we can always realign our priorities to reflect what the future requires instead of what the past dictates. Change is difficult and it can be uncomfortable as we transition from the old paradigm to the new. But we must reform the way we do things in order to better serve the people of Massachusetts and to provide the needed care and support.

HOUSE 1

The Governor's fiscal year 2010 H.1 budget proposal includes new revenues and additional cuts from within EOHHS. The budget proposes $27.97 billion in spending, approximately $200 million below the FY09 GAA. Some areas, like MassHealth, will experience growth, but other areas of the budget were cut nearly $1 billion, including $621 million to executive branch agencies.

In terms of new revenues, the Commonwealth Wellness Fund was established in FY09 and eliminates the sales tax exemption on alcohol, candy and sweetened beverages. As a result, an estimated $121.5 million in new revenue will be deposited into a new Commonwealth Wellness Fund in FY10. These resources will pay for addiction and tobacco control services, as well as health promotion, violence prevention and workforce expansion programs.

Line Item Account Consolidation

Over the past 2 years, Governor Patrick has worked with his Cabinet to explore opportunities for a more efficient way to develop the annual budget. Those discussions have focused on developing budgets based on programs rather than individual line items, which are inconsistent in that they fund partial or multiple programs.

The line-item approach does not allow for agencies to develop their budgets based on programs and priorities. As a result, the fiscal year 2010 budget includes line-item consolidations that are a step in that direction.

This structure is not meant to disguise the significant reductions in agency budgets, a reality we readily acknowledge. Rather, it is meant to provide maximum flexibility for Secretariat and Agency heads to manage within limited resources.

The FY09 GAA includes 176 accounts for Health and Human Services agencies. Through consolidation, FY10's H.1 budget reduces the account total to 74 -- a reduction of 102 or 58%.

Health Care Reform and Cost Containment
Building upon the tremendous success of health care reform, the Administration's fiscal year 2010 budget continues to fully fund expansions in coverage through state health insurance programs for low- and moderate-income families.

These investments reflect a continuing commitment to health care reform and the recognition that the MassHealth and Commonwealth Care programs are core components of the safety net for low-income residents of our state, including individuals who may have recently lost their jobs or private health insurance due to the economic downturn.

Despite the significant fiscal pressures facing the Commonwealth, the budget does not cap enrollment or cut benefits for state health insurance programs, as has been done in prior fiscal crises.

The budget also includes $880 million for Commonwealth Care, a 7.3 percent increase over current fiscal year 2009 projections, to provide coverage to approximately 180,000 residents. Enrollment is expected to resume moderate growth in fiscal year 2010 -- the result of the loss of employer-sponsored insurance that typically accompanies negative economic conditions. Under a new payment methodology, rate increases have been limited well below medical inflation.

MassHealth's budget for FY10 includes $8.97 billion. Excluding spending that was previously off-budget, MassHealth's fiscal year 2010 budget totals $8.68 billion -- a 3.14 percent increase over estimated fiscal year 2009 spending. Through eligibility expansions and enrollment of eligible individuals through the Virtual Gateway, a more streamlined member-tracking system, MassHealth has seen caseload increases in recent years. The fiscal year 2010 budget continues to fund projected enrollment growth in the MassHealth program.

The MassHealth budget also reflects a total of $357 million in gross savings ($178 million in net savings) that includes $25 million in gross ($12.5 million net) targeted investments needed to achieve many of these savings. Categories of savings include limiting rate increases, expanding pay-for-performance, service program changes (providing coordinated care in appropriate settings), utilization management (e.g., expedited claims review), pharmacy savings and other savings (e.g., elimination of certain grants and pilots).

On the flip side, health care cost containment is on everyone’s mind.

We are committed to reforming the way we pay for health care away from a fee-for-service system that rewards providers who do more, especially more high-tech and tertiary care, while primary care, behavioral health services and community hospitals continue to be under funded. We are engaged in a process that will result in recommendations about reforming the payment system.

But we are focused right now on using our MassHealth authority to design and implement models for the patient-centered medical home. Our hope is that by focusing on a Patient-Centered Medical Home we will see improvements in the quality of care, enhanced patient experiences and reductions in health care spending trends.

The goal is to transform primary care practices so that they provide continuous, comprehensive and coordinated care to their patients, with broadened access and greater use of multi-disciplinary teams and electronic health records to care for the chronically ill.

Accomplishing this will require both payment reform and an investment of resources to help physicians re-engineer their practices. Because this reform is aimed at practices rather than populations, it is by nature a multi-payer effort.

POS Reform

We are making significant progress implementing Chapter 257, the statute first introduced as Senate Bill 65. As you know, it places authority for development of social service reimbursement rates with the Secretary of Health and Human Services. Our responsibility is to ensure that these rates are fair and adequate, and that providers of these services are afforded a regulatory and public hearing process to ensure transparency and adequate venues for feedback.

The Division of Health Care Finance and Policy has responsibility for implementing rate reform according to the four-year timeframe specified in the statute. As HCFP implements the law, we will simultaneously reform procurement and contracting within the purchase of service system. This will simplify these activities for human service providers and our agencies, while also lead to significant administrative efficiency, improved internal controls and better ways of measuring quality and performance. All of these measures will ensure that the dollars allocated to these services are spent well and with efficiency.

Obviously, implementing this statute comes at a difficult time. In many cases, we anticipate that HCFP analysis that will result in reimbursement rates that are higher than what they are today. In order to implement this law in the current budget environment -- where new funding is not available -- we may be required to reduce the volume of services we purchase. Or, we may need to re-design services to make them less intensive, and therefore, less costly. We will continue to monitor the impact of all of these forces on Chapter 257 throughout FY10.

Competitive, Integrated Employment Services Program

Also in the reform arena, last week EOHHS released an RFR to human service providers for proposals to deliver employment placement and support services to individuals served by four of our agencies.

This joint procurement is our first work under Chapter 257 and our procurement and contracting reform initiative. With a shared approach to contracting, the Competitive, Integrated Employment Services Program extends significant administrative simplification to both providers and HHS agencies.

It replaces six different employment services programs – all of which shared the same essential program components to begin with – with a single model that has the flexibility to address different levels of client need. With this program, we have eliminated six different procurement cycles, six different service reporting requirements, six different contracting approaches and six different payment processes. The end result will be a greatly simplified approach to service management and delivery in FY10 and beyond.

This is also a performance-based program. Providers of services are paid for their effectiveness in supporting clients to achieve a series of milestones along the way to employment. In this economic environment, rather than pay for slots and service delivery regardless of whether our clients are getting jobs, we've placed a clear set of incentives for job placement. This will ensure that we are doing all we can to bolster the economic stability and welfare of the individuals and families we serve.

Agency Collaboration: Case Management within CYF

Another collaborative effort across our agencies is case management services within the Children, Youth and Families cluster.

Breaking down silos has been a major goal of mine, as well as the Governor.have begun to accomplish this through improved data sharing and an innovative care coordination model, One Family One Plan.

The goal of One Family One Plan is to coordinate planning for children and their families who receive services from more than one of the Children, Youth and Families agencies. As a result, care plans are coordinated and aligned; benefits are offered earlier in transition when a child is returning home from DCF custody; and case workers are learning about the myriad of benefits available outside of their agencies and connecting their clients to these services.

As we work with agencies outside of, such as Education, the information provided about the educational progress of children served by the Department of Children and Families and the Department of Youth Services is used to provide support services.

Governor Patrickus to realize that working together across agencies and across secretariats, we can accomplish great things. During these difficult economic times, we will continue to work together to pool resources and streamlineto be effective, efficient and responsive to the needs of families.

IT Consolidation
Within the FY10 budget proposal, the Administration's has also identified the Commonwealth's current decentralized IT management and funding structure as inefficient in many ways. In response, IT leaders from across the Commonwealth collaborated in developing a plan titled: "IT Strategy for the Commonwealth: 2009-11."

The plan identifies Secretariat consolidation as one of seven key initiatives that must be pursued to build the foundation for the Commonwealth's technology future.

The goals of Secretariat consolidation are to:

- align Secretaries' IT resources with their business strategies and priorities;
- standardize IT resources and create efficiencies; and
- align Secretariat IT plans with the Commonwealth IT Strategic Plan.

A successful consolidation will streamline IT operations to reduce costs, improve data-security and enable agencies to provide efficient and easily accessible services for all constituents. Additional benefits include:

- Improved Service Delivery – Residents increasingly expect a seamless experience when dealing with government. Secretariats will now be able to more easily create a single point of entry for multiple services from multiple agencies.
- Improved Decision-Making – Accurate and timely data on our IT systems will enable better decisions and strategies to manage the Commonwealth's increasingly complex IT resources.
- Reinvestment of Funds – Cost savings will enable Secretaries to reallocate resources to address immediate needs or create long-term benefits.
- Infrastructure and Maintenance Upgrades – By simplifying our networks and standardizing our systems, the Commonwealth will be able to better monitor, maintain and upgrade major systems.

The H.1 recommendation for EOHHS includes a new account, 4000-1700, for secretariat IT consolidation. Consistent with the Commonwealth's Strategic IT plan, H.1 reflects a consolidation of agency IT resources at the secretariat level, with the goal of streamlining IT operations, improving efficiency and better aligning IT with the Administration's strategic goals.

The $94.4 million new direct appropriation at EOHHS incorporates transfers of IT resources currently budgeted at all 16 of our agencies.

OTHER PRIORITIES

Community First

We remain committed to making the Olmstead Plan that we announced last year more than a paper document, but a reality for people with disabilities and elders. Our comprehensive Olmstead Plan ensures that people with disabilities and elders have access to the full range of services and supports they need in the community so that they can live with dignity and independence.

As part of this plan, we announced a plan to close four of the state's six institutions for people with mental retardation over the next four years. Reconfiguring the Department of Mental Retardation's facilities system to focus more on community-based living options will significantly enhance community integration and improve quality of life for people with disabilities.

We are fully engaging with family members and guardians in a thorough, person-centered planning process to ensure that all of our consumers in these institutions receive equal or better
care in their new settings.

Elders

At the Executive Office of Elder Affairs, we have received four grants from the United States Administration on Aging totaling more than $1 million – all of them intended to expand and support ways to keep seniors at home or in their communities for as long as they wish to be there.

These grants will:

- Develop a statewide Aging and Disability Resource Center network to provide for the development of a sustainable Long Term Care Options counseling model.
- Evaluate at-risk veterans, connecting them with home- and community-based services, thereby avoiding or delaying nursing home placement.
- Fund the development of a partnership between Elder Affairs and the Alzheimer's Association to help persons with Alzheimer's avoid or delay nursing home placement.
- Develop three surveys that examine outcomes over time for clients receiving home-based services; to identify predictors of nursing home placement; and to construct a model that would predict the likelihood of nursing home placement.

DMH

The Department of Mental Health is also making ground-breaking advancements in its work by transforming its adult community system. The Community Based Flexible Supports transformation is shifting the agency to one that sets standards, provides oversight, monitors and assures that the same level of quality services are being provided to everyone who needs them as we create a mental health system that is based in recovery, resiliency, partnership and consumer choice.

Some of the features of the transformation include person-centered care; integrated treatment planning; a peer workforce; enhanced clinical expertise; and service and pricing models that facilitate flexibility.

It also includes age appropriate services for transition-age youth who have taught us that services for this population are specialized and different than adult services.

Working Together

These are hard times and for those of us who come to this work because we believe we can make a difference it is particularly difficult. As I physician I know that people who care often ask “What more can I do?” Doctors believe they have not healed enough. Parents want to do more to protect their children and build for their future. Community leaders cannot stand one more tragedy, one more community trauma. Those of us in government cannot stand by knowing that we cannot protect all of the vulnerable because of a lack of financial resources.

I joined the Patrick Administration because I believe that government should play a role in making sure that everyone has opportunity, safety and health, and that government must assure that the most vulnerable achieve these goals. I know that we are all committed to getting to the same goals. I believe, as the Governor does, that we can do this together.

In the coming year we must work together to face the challenges ahead. I look forward to working through these challenging times with all of you and your colleagues in the Legislature, spreading hope for the future and celebrating what I know will be our successes together.

Thank you.

OFFICE OF MEDICAID

Good morning Chairwoman Fox, Chairman Hart, and members of the Committees on Ways and Means. I want to thank you for the opportunity to present the MassHealth program and our fiscal year 2010 budget proposal. MassHealth is the Commonwealth's Medicaid program and, as you probably know, constitutes over 32% of the overall state budget. MassHealth pays for health care for over 1 million people – 1 out of every 6 Massachusetts residents. Our members are children, adults, seniors and individuals with disabilities. For each of them, our job is to provide a comprehensive and well-run health insurance plan. In today's economic climate, our job increasingly is to find efficiencies in the program so that we can continue to provide health coverage without unduly burdening the state budget. I am proud of our record in this regard and look forward to sharing with you our plans for even greater efficiencies in this fiscal year I want to take this opportunity to thank the General Court for the attention and financial commitments it has made to MassHealth year after year. Without your support, we could not do our work to protect the health of the state's neediest families and children.

FY10 HOUSE 1 BUDGET

House 1 includes $8.9 billion for MassHealth, which supports a 6.6% increase over fiscal year 2009. This growth includes moving $290M in spending not previously in the MassHealth budget (including the Children's Behavioral Health Initiative, the Essential Community Provider Trust Fund, and certain hospital and physician rate payments and pay-for-performance payouts) into the MassHealth budget. MassHealth program spending for FY10 will grow by approximately 3% after adjusting for these new on-budget items. After adjustment for anticipated enrollment growth, MassHealth projected program spending growth for FY10 is an astoundingly low negative 0.3%.

And yet, we are not proposing limiting eligibility for any population or eliminating any service in this budget compared to FY09. Our commitment to cost containment makes this possible and I am very proud to come to you with this proposal. The FY10 budget projection assumes coverage of 1,231,000 MassHealth members in FY10, a 3.5% increase from the FY09 projected caseload.

As always with Medicaid spending, that appropriation must be seen in the context of the revenue it generates: we project that MassHealth spending will result in $4.3 billion in revenue to the General Fund in FY10.
MassHealth's initial adjusted FY2010 budget request is $8.6 billion after proposed savings initiatives of $383 million and investments of $25 million off of maintenance forecast. The savings and investments proposed support MassHealth goals while keeping membership and services intact.

Managing spending is not a new initiative for MassHealth. Medicaid eligibility has historically been expansive as compared to other states. At the same time, tax rates have been going down in Massachusetts and are below the national

average. Meanwhile, over the last decade Massachusetts has experienced a rate of per capita health care spending that is 25% higher than the US average. These factors have forced MassHealth to maximize efficiencies in the program as a standard business practice.

Our constant challenge is to be sure that our sending policies are informed by a consistent strategic direction. Throughout the Patrick Administration, that strategic direction has been clear and includes:

- Clinical innovation, in the form of quality improvement initiatives and value-based purchasing;
- A focus on primary care and improved managed care for all members; and
- An emphasis on cost-effective community-based services for members with chronic health care needs.

MassHealth's FY10 spending plan is informed by these major policy imperatives.

MASSHEALTH AND HEALTH CARE POLICY

MassHealth, as one of the Commonwealth's largest health insurers, is committed to excellence in operations and customer service as the essential backdrop to all of its strategic goals. The Commonwealth has made a significant investment in a new claims processing system, the New MMIS, which will come on line this year. This project remains a major priority and in FY10 the New MMIS system will be an important tool in implementing our strategic priorities. We strive to run MassHealth like an insurance plan – like the sophisticated business it is. But I understand that MassHealth is much more than a way for the state to pay insurance claims – it is a vehicle for making policy decisions. The MassHealth program, with direction from the legislature and in consultation with our partner agencies, makes choices, about how we arrange our delivery systems for members, how we reimburse our providers for services, how we make our budget investments, and even how we structure the budget savings that are required year-to-year. Those strategic choices amount to an important component of health care policy and outcomes in the Commonwealth.

In Governor Patrick's FY10 budget both our planned savings and our proposed investments reflect MassHealth's leadership in health care policy. We propose to reshape managed care in MassHealth, with a strong emphasis on quality care and on new and innovative strategies to enhance primary care. We continue a multi-year and multi-faceted initiative to rebalance long-term-care spending in the Commonwealth, with a significant new investment in MassHealth's Community First policy. We are embarking on a new and essential initiative to coordinate behavioral health services for children. And perhaps most prominent among Governor Patrick's health care policies, we are committed to ensuring the success of the Health Care Reform effort begun in 2006.

HEALTH CARE REFORM

The Commonwealth's health care reform effort has been an impressive

accomplishment, whether you think of it in terms of operational effort, financial commitment, or policy innovation. The bottom line is that earlier this year a survey found that 97.4% of Massachusetts residents have health care coverage—a level far higher than in any other state.

MassHealth's most important role is to be the operational and financial underpinnings on which this reform is built. Programmatically, Chapter 58, the comprehensive health care reform bill, has created a more expansive and more comprehensive MassHealth program, with expansions of eligibility for children, low-income uninsured adults, and individuals with employers that want to participate in our Insurance Partnership program. Taken together, these eligibility expansions, combined with a greater emphasis on outreach, have resulted in an increase in MassHealth enrollment of 76,000 since the passage of chapter 58.

The FY10 budget proposal maintains the commitment to health reform. As you are all aware, we worked hard, and successfully, to negotiate an expansion of the federal waiver that maintains the federal authority and commitment to health care reform and will bring approximately $2 billion additional federal dollars into the Commonwealth.

There is still work to be done. We are fully engaged in the next necessary phase of health care reform, to contain costs across the program and improve quality across the health care system. While we have led the country in providing access to high quality health insurance, we must now demonstrate that we can lead the cost containment strategies that make our commitment possible and sustainable. Our FY10 budget proposal includes a wide range of cost containment initiatives designed to further restrain state costs, promote higher quality and more cost-effective care, advance reform of our health care payment system and improve coordination of benefits and payments.

KEY STRATEGIC INITIATIVES

Pay For Performance

Over the past few years, MassHealth has moved aggressively to implement performance-based payments for hospitals, nursing homes, physicians and managed care organizations. MassHealth will continue this initiative in FY10 by increasing the proportion of payments subject to performance improvement and achievement. P4P payments for hospitals, for example, will reach approximately 10% of the $1.1 billion estimated spending on non-MCO hospital payments.

MassHealth will realize $62M by expanding the amount "at risk" for hospital and nursing facility FY10 Pay for Performance (P4P). These incentive payments will be made in FY11. In addition, MassHealth will pay an estimated $40.6M in FY10 in P4P for hospitals that meet predetermined success thresholds. This will create additional savings of $17M, because MassHealth will only distribute FY09 P4P monies where the performance benchmarks were met, and will not adjust the thresholds to ensure

the total amount budgeted in FY09 ($58M) is distributed.

Hospital-Acquired Infections and Preventable Readmissions
MassHealth will stop paying for certain hospital-acquired infections (infections that patients acquire while receiving treatment for medical or surgical conditions) or preventable readmissions. This proposal will provide a financial incentive to improve patient care and avoid unnecessary costs. It builds upon an earlier announcement through the Administration's Healthy Massachusetts Initiative that MassHealth, Commonwealth Care, the Group Insurance Commission and the Department of Corrections – which collectively insure or purchase care for 1.6 million lives – would no longer pay for costs associated with 28 serious reportable health care events.

Provider Rates
Given extremely limited budget growth overall and expected MassHealth enrollment growth, planned rate increases to providers are effectively eliminated across the MassHealth program. Increases in capitated rates paid to managed care plans, including MCO plans, the Massachusetts Behavioral Health Partnership, and SCO and PACE plans are effectively eliminated.

Community Long Term Care rate increases for Adult Day Health, Adult Foster Care, Day Habilitation, and Group Adult Foster Care are not funded in House 1. However, spending on these programs is expected to total over $300M in FY10, which supports an expected 8-10% increase in utilization. This dynamic is repeated across the program.

In the area of nursing facility rates, House 1 proposes a new structure as a way to support that important component of our program. Federal law allows for the nursing facility assessment or "user fee" to be up to 5.5% of gross revenues for the industry. The current assessment is $145M. This initiative proposes to increase the percentage of gross revenues assessed, for a total assessment to the industry in FY10 of $220M. This proposal would increase the assessment and return all of the revenue to the nursing facilities through maintenance of current rates, a rate increase of $15M, and $35M in FY09 P4P payouts. In total, the nursing home industry will see an increased user fee of $75M and an increase in spending above baseline of $50M for a net negative $25M impact. In addition, $55M in FY10 P4P will be paid out in FY11.

Program Integrity Efforts
MassHealth continues to be a national leader in ensuring the integrity of the funds provided by the taxpayers of Massachusetts. MassHealth is procuring a state-of-the-art augmented service utilization and review system that will use advanced analytical techniques to ensure fraud and abuse are addressed aggressively. We will also be increasing clinical reviews across many provider groups to ensure members receive the most appropriate level of care. Furthermore, we will be continuing our leading efforts to ensure Medicaid is the payor of last resort and all third-party liability opportunities are identified.

Alternative Payment Demonstration
As an alternative to "fee for service" payments to providers that can promote "over-delivery" of care without better results for patients, MassHealth plans to develop alternative payment demonstrations with interested hospitals, physician groups and nursing homes. This project will establish an aggregate prospective payment to cover the total cost of a defined set of health care services delivered by a provider or provider system. The goal of the global payment demonstration is to enhance incentives for providers to manage costs and utilization, integrate services, and focus on quality, as opposed to volume. Development of this model will be informed by the work of the newly created state Special Commission on Health Care Payment System.

Managed Care and Primary Care Enhancements
FY10 will be a very important year for MassHealth's managed care programs. We currently have over 719,000 members who are served by our Primary Care Clinician Plan (the PCC plan) and our four Health Plans (the MCOs). A major strategic priority reflected in our plans and in the FY10 budget is to improve this delivery system. We are reprocuring our MCO contracts, with updated contract requirements, a focus on quality measurement, and an emphasis on real competition.

In addition, we will be re-shaping the PCC plan to serve our members more effectively. Because we believe a stronger focus on care management and disease management will both improve care for our PCC plan members and save money, MassHealth's House 1 budget proposes to expand care management capacity. We assume some savings from implementing new medical management initiatives, but recognize that those initiatives, properly done, take resources. The improvement of the PCC plan will also focus on the movement to a Medical Home model of care provision. We will institute a Medical Home demonstration program in certain primary care practices, in collaboration with other health insurers, with the goal of enhancing payments for primary care providers and supporting patient-centered and coordinated care to members.

Community First
An equally important and far-reaching policy is the Commonwealth's "Community First" initiative to rebalance spending and utilization in the-term care system. This initiative expands on important home and community based service development that has already taken place through the long term care programs of the Executive Office of Elder Affairs, the Executive Office of Health and Human Services, and MassHealth. Community First is the Administration's long-term care policy, a multi-faceted initiative that will give elders and people with disabilities more choices so they can remain at home and in their communities. The demographic reality that increasing numbers of residents are likely to be in need of long-term supports highlights the importance of this policy commitment.

MassHealth is embarking upon several initiatives to provide members with more

choices for community-based services. House 1 allows MassHealth to implement a "Cash and Counseling" program to allow MassHealth members receiving certain long-term care community services the option of receiving a cash benefit in lieu of services so that they can make alternative arrangements for their care that best fits their circumstances, needs, and preferences. Members who select this option would be assisted by a support broker who would help the member develop a service plan based on the individual's budget. Settlement of the Rolland v. Romney case will expand community care options for individuals with mental retardation and developmental disabilities, and settlement of the Hutchinson v. Romney case will expand important community alternatives for brain-injured adults and seniors.

House 1 includes $21M to begin offering new services as we continue to work for the approval of the pending Community First 1115 waiver in FY10.. We intend to target first reaching those members who do not currently have access to home- and community-based services and also to expand services modestly for our members who have some home- and community-based services now.

Rosie D./Children's Behavioral Health Initiative

Finally, House 1 recognizes that MassHealth is in the process of coordinating the implementation of a comprehensive and ambitious statewide plan in response to the Rosie D lawsuit concerning behavioral health services for children. This Children's Behavioral Health Initiative, or CBHI, plan will result in major improvements in the ways we coordinate health care for our most vulnerable children. The plan will also cost more money over time. We do expect that successful implementation will require new resources in the coming fiscal year; the House 1 budget includes $43.5 million towards this effort. I do want to bring to your attention, however, that we have just been informed by the Court overseeing the lawsuit that certain revised timelines we proposed to the court were accepted only in part. We will communicate to Ways and Means staff when we assess more fully the impact of this change in implementation plans on the FY10 funding level. The FY10 funding level is an increase of over $18.5M from the FY09 spending.

MASSHEALTH LINE ITEM CONSOLIDATIONS

Our new consolidated line item approach is much more logically connected to the way MassHealth manages its programs. Two existing line items will be maintained independently and the balance of the MassHealth budget will be structured in a way that is consistent with the organization of the program. Those four major line items encompass payments for members in capitated managed care plans (4000-0500), payments for members in MassHealth's primary care clinician plan (4000-0740), payments for members not in managed care or the PCC plan (4000-0700), and premium subsidies or payments for members with private insurance or Medicare (4000-0835). MassHealth's current line-item structure is mystifying to the public, lacks transparency, and has no relationship to the actual management of the program.

There is one other important matter I want to point out that relates to these line-item consolidations. One of the larger re-organized line items is currently the "Senior Care" line item 4000-0600. I want to assure you that this does not represent a major change in the way we now do our work with the Executive Office of Elder Affairs. As a practical matter, we have always managed the MassHealth budget as a comprehensive whole. When it relates to matters affecting seniors, we are committed to doing so, as we do today, in partnership with the leadership of the Executive Office of Elder Affairs and the other state agencies who help us serve our members.

CONCLUSION

Overall, we are proud of this budget proposal and we believe it makes the right choices about how to move the MassHealth program forward in this challenging environment in FY 2010. We are always happy to work with you and respond to any question posed by your staff to help work through the details as you build your own budgets.

I appreciate your commitment to this program. Thank you.

DEPARTMENT OF PUBLIC HEALTH

Chairman Hart, Chairwoman Fox, thank you for allowing me this opportunity to make these brief remarks before the Committee today; first by recognizing the challenges and monumental task you face and wishing you the best of luck in the new session. We look forward to working with you to promote the good health of all of the residents of our state. And, to the other Committee members let me say a very public thank you for your support of the Department of Public Health.

As I approach my second year anniversary at the Department, I cannot tell you what a privilege it is for me to lead this remarkable agency that is comprised of a very dedicated and committed staff. These people work hard every day to improve the health of many vulnerable populations in our state -- and it is an honor to work with them. Our work touches every person in this Commonwealth, but it is most important for the very young, the elderly, the poor, the disabled, the homeless, people of color, and for others who are often over-burdened with health problems and sometimes underserved by the health care system.

As you have heard all too often, from every state agency, our biggest challenge right now is how will we meet our many obligations -- the central mission of our work -- during the greatest economic downturn since the Great Depression. I don't have a quick and simple answer to that question, but I can tell you that we will continue as we have since the beginning of this budget crisis -- to be thoughtful and diligent with respect to every programmatic decision that we make, to minimize the effects of the cuts, and do our best to protect core public health services.

The Governor's FY10 budget proposal for the Department of Public Health is a lean but unavoidable budget given the fiscal times that we find ourselves in. It provides $537 million dollars to fund the work of our ten bureaus and our nearly 100 public health programs, including our four public health hospitals and the Hinton State Laboratory Institute.

The approximately 11% reduction in funding for FY10 will be felt by every area of DPH, and will likely force significant reductions or closure of certain treatment services provided in our hospitals, and the scaling back of a number of our prevention and health promotion programs.

As I have said we are working hard to maintain many core services, and that is evident in our funding proposal for Substance Abuse Services, which leaves virtually all the current services intact.

The Governor's proposed budget also provides level funding for our Women Infants and Children nutrition program. The WIC program is incredibly important and vital in these tough economic times and the Governor's budget recognizes that.

And, Governor Patrick continues his leadership in support of domestic violence prevention efforts by providing $6.3M in level funding for domestic violence and sexual assault prevention and treatment services.

Opportunities in times like these can be hard to come by; however, I do think we have opportunities to support the work of DPH and of public health throughout the Commonwealth. One such opportunity is the Governor's proposal for creation of the Commonwealth Wellness Fund. The creation of this fund is a bold and innovative idea, and the revenue generated from lifting the sales tax exemption from some non-nutritious foods and off-premises alcoholic beverages could greatly benefit important public health prevention and promotion activities – like smoking prevention and cessation where we have made great strides. Last year we announced that youth smoking rates had declined to 17%, the sharpest drop in several years. And, our adult smoking rate last year was the lowest ever recorded, and according to CDC was the 4th lowest smoking rate in the nation. The proposal for the Wellness Fund makes a statement -- that even in difficult economic times, prevention is important and we need to find a way to pay for it.

We will continue our groundbreaking efforts on ending racial and ethnic disparities in health. Last year we issued 4 new reports on the impact of health disparities on residents of color in Massachusetts. We hired Georgia Simpson May as the Director of DPH's Office of Health Equity to lead our efforts and we have taken steps to diversify the leadership of the Department of Public Health. The FY10 budget maintains $1 million in funding for our disparities.

We will also continue to prioritize health care quality in the Commonwealth, by working with the Quality and Cost Council and successfully implementing new regulations to require hospitals to report and prevent Health Care Associated Infections and serious medical errors, thereby saving lives as well as millions of dollars in health care costs.

We will work through the Public Health Council to continue our efforts at sensible health policy regulation, building on our success of last year when we strengthened the DoN process, protected community hospitals, and expanded care options for residents seeking convenient, minor medical care at Limited Service Clinics.

And, we will also continue our work to address the major causes of chronic disease in our state by supporting our wellness initiatives that will help keep people healthy at home, at work and in their communities. As you may know, in January we had a very successful launch of our Mass In Motion campaign, which is the most comprehensive state effort to date aimed at addressing the epidemic of overweight and obesity in our state. That program is a great example of how we can move a major health initiative forward with limited state funding. Thanks to the widespread support of the major health foundations in the Commonwealth,

we will be able to distribute nearly $750,000 in the coming month to help cities and towns kick-start wellness initiatives in their communities. And we will soon pass regulations that help our state's residents by providing them with useful information about the calories in fast foods at the point of purchase and by offering parents information about their child's health status.

This year will surely be full of difficult challenges but public health has a history of dealing with adversity. We appreciate your help and support as we move forward, and I promise you that my DPH colleagues and I will continue our efforts to preserve and promote the health of all of our residents – even while the budget contracts.

Thank you.

DEPARTMENT OF MENTAL HEALTH

Good morning, Senator Hart, Representative Fox and Ways and Means Committee members. I am honored to be here today to discuss the Department of Mental Health House 1 budget. In this difficult economic climate, it is vital that we work together to ensure that our most vulnerable citizens are not forgotten and I appreciate your leadership and hard work on behalf of adults, children, adolescent and families with serious mental illness and your support of the mission of the Department of Mental Health.

There is little good news about our economy today. We are facing the most significant downturn since the Great Depression. We are anxious about the future. We are concerned for the individuals we serve. The 9C reductions for DMH required us to make painful decisions and behind every one of those decisions is a person, a family, a colleague, all of whom rely on DMH for much needed services or their livelihood.

Our *mission* is to provide access to services and supports to meet the mental health needs of individuals of all ages, enabling them to live, work and participate in their communities. We envision a world in which recovery is possible for all citizens with mental illnesses. Our goal at DMH is to help consumers re-establish their lives in their communities—jobs, homes, relationships—things that you and I recognize we all desire; for some individuals with mental illness, their lives were tragically interrupted by mental illness and we need to support the realization of their dreams.

We are committed to cultivating and promoting partnerships and infusing the principles of recovery and resiliency in our services, culture and approach to treatment. Treating people with respect, dignity and supporting their self-direction is core to our work. We embrace the principle that a consumer-centered mental health care system is the foundation of transformation.

The Department of Mental Health serves 21,000 people. These are adults with serious and persistent mental illness and children and adolescents with mental illness and serious emotional disorder. Our services include inpatient care in our hospitals; intensive residential treatment; emergency services; case management; and other community and rehabilitative services. The Department operates three psychiatric hospitals, two psychiatric units in Department of Public Health operated hospitals, seven community mental health centers, and one contracted psychiatric unit. DMH also regulates and licenses all private psychiatric facilities.

Governor Patrick's House 1 budget for FY2010 addresses the serious budget realities we face as a Commonwealth. It also presents the Department of Mental Health with the opportunity to transform our public behavioral health system. Today, DMH offers program-specific treatment in which consumers are placed in programs. A transformed DMH will allow providers to tailor services to meet flexibly the needs of consumers. Today, outcomes are focused on the system; our future embraces a focus on person-focused outcomes that demonstrate an individual's improvement.

Today, there are barriers to easy transition between inpatient and community levels of care. Our future will support seamless movement for consumers throughout the DMH continuum of inpatient and community services.

House 1 for FY2010 reduces our appropriation by $50 million from the beginning of FY2009 to the start of the upcoming fiscal year. Part of the reduction is already addressed in our FY2009 9C reductions and the concomitant annualization. Going into FY2010, the Department has a budget gap of $24 million. Despite this significantly reduced funding level, the Department is moving forward with its transformation. DMH will shift to an agency that sets standards, provides oversight, monitors and assures that the same level of quality service is based in recovery, resiliency, and consumer choice.

As we approach this challenge, it is crucial that we maintain focus on our core mission. During the very painful 9C cuts, we had little choice but to make reductions in our community services systems, which included case management and certain community programs. Case management is a vital and highly valued part of DMH's community-based mental health service system and it is my intention that this service continues to be provided by DMH case managers. As we anticipate more difficult decisions in the next fiscal year, I am committed to preserving the vital community services that enable our consumers to recover and live productive lives in their communities.

We are therefore looking at an inpatient consolidation plan with an eye toward the new DMH hospital, which is scheduled for completion in the spring of 2012, and plan to accelerate the redesign of our inpatient system. We are in the process of developing such a plan that includes the consolidation of forensic evaluation services; a reduction of inpatient bed capacity; and the transition of inpatient clients ready for discharge to the community, aligning our efforts with the Community First/Olmstead Plan.

Instead of a crisis, I see an opportunity for the Department to approach its responsibilities differently. It is our opportunity to confront longstanding issues and make our public mental health system sound, resilient and more responsive to the needs of the citizens we serve while meeting our budget realities. I remain committed to the Department of Mental Health as the bridge of hope for adults, children, adolescents and families with serious mental illness.

I thank you for the opportunity to address this committee. I would be pleased to answer any questions you may have.

DIVISION OF HEALTH CARE FINANCE AND POLICY

Good morning Representative Fox, Senator Hart, and distinguished members of the House and Senate Ways and Means Committees. My name is Sarah Iselin and I serve as Commissioner of the Division of Health Care Finance and Policy, an agency within the Executive Office of Health and Human Services. I appreciate this opportunity to discuss the Division's responsibilities and ongoing initiatives.

The mission of the Division is to improve the delivery and financing of health care by providing information, developing policies, and promoting efficiencies that benefit the people of the Commonwealth. The Division has four key priorities:

- Analyze health care cost trends and cost containment options to support the sustainability of health care reform;
- Facilitate the continued success of health care reform and monitor its progress by collecting, analyzing, and disseminating information;
- Manage the Health Safety Net (formerly the Uncompensated Care Pool); and
- Support Purchase of Services reform by standardizing rate setting methodologies for human service programs.

I will expand upon the Division's role and responsibilities related to each of these priorities.

Health Care Cost Containment

The sustainability of health care reform requires focused efforts to control health care cost growth, and the Division is committed to informing and galvanizing these community conversations. Indeed, recent legislation significantly expanded the Division's statutory authority and responsibilities to explicitly include efforts related to monitoring health care cost trends. Specifically, under *"An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care"* (Chapter 305 of the Acts of 2008), the Division is required to perform several new tasks.

Under Sections 20-24, the Division is now responsible for filing an annual report on health care cost trends with recommendations to the legislature by December 31st of each year. The Division will also hold annual public hearings regarding factors that contribute to cost growth within the health care system. The Division will issue a preliminary report 30 days before the hearing providing information based on its findings and will use this preliminary report as a basis for designing the format and content of the hearing. To facilitate this analysis, the Division will be able to collect data (without limitation) from private and public health payers.

Section 35 directs the Division, in conjunction with DOI, to examine options and alternatives available to the Commonwealth to provide regulation, oversight and

disposition of the reserves, endowments and surpluses of health insurers and hospitals. We will file a report with our findings and recommendations to the legislature by July 1, 2009.

Section 44 created a Special Commission on the Health Care Payment System to investigate reforming and restructuring the payment system in order to provide incentives for efficient and effective patient-centered care and to reduce variation in the quality and cost of care. Secretary Kirwan and I serve as co-chairs of the 10-member Commission and we expect to release a report with its findings and recommendations by late May.

These new responsibilities complement the Division's existing efforts to monitor health care cost trends, including:

- The Division provides ongoing support to the Health Care Quality and Cost Council. For example, the Division calculates the quality and cost indicators that are displayed on the Council's consumer-friendly website. We have also convened an expert panel to select a whole system hospital mortality measure. In addition, the Division provides contract management, legal, information technology, and communications support to the Council.
- The Division is currently conducting a pilot of 3M Potentially Preventable Readmissions software. The goal of the project is to evaluate the 3M PPR methodology for use in quality improvement and potential public reporting through a collaborative approach with hospitals. The Division will provide readmission reports to all acute care hospitals and seek a smaller set of pilot hospitals to participate in the validation portion of the project.
- In collaboration with RAND, the Division is assessing experiences with various cost containment options and modeling the potential impact of these strategies in Massachusetts. The report will be released this spring.
- As required by M.G.L. Chapter 3, Section 38c, the Division conducts cost-effectiveness analyses of new mandated health benefits being considered by the legislature. In the coming months, we will release reports on 5 bills: continuity of prescription drug coverage, vision screening, prescription drug-voice synthesizers, cleft lip and palate, and urea cycle disorders.

Health Care Reform

The Division also plays a critical role in overseeing a few key components of health care reform. Under Chapter 58, the Division was charged with implementing three responsibilities affecting Massachusetts employers: the Employer Fair Share Contribution, the Free Rider Surcharge, and the Health Insurance Responsibility Disclosure (HIRD) Form. We work closely with staff from the Department of Revenue (DOR), the Commonwealth Health Insurance Connector Authority (CCA), the Division of Insurance (DOI), and the Division of Unemployment Assistance (DUA) to coordinate implementation of the related regulations.

The Division's Fair Share regulation governs the determination of whether an employer with 11 or more fulltime equivalent employees (FTEs) makes a "fair and reasonable premium contribution" to the health care costs of its employees. Employers who do not meet the standard are subject to a Fair Share contribution. In fall 2008, the Division adopted new regulations that changed the test threshold for employers with 51 or more FTEs. As of January 1, 2009, these employers must achieve at least 25% enrollment of fulltime employees in the employer's health plan and offer to contribute at least 33% of the cost of the plan to all fulltime employees. Alternatively, these employers may avoid a compliance liability if they achieve enrollment of 75% or more fulltime employees into their health plan. The threshold for small employers (with between 11 and 50 FTEs) remained the same with employers having to demonstrate either than that they achieved 25% enrollment OR they contribute at least 33%. The fall 2008 regulation changes also included a move to a quarterly reporting structure as required by Chapter 302 of the Acts of 2008. The Division of Unemployment Assistance is responsible for collecting Fair Share Contribution payments from employers.

Chapter 58 also required the Division to assess a surcharge on Massachusetts employers for state costs incurred in providing free care to an employer's employees or employee dependents. Under the Division's regulation, a surcharge will be imposed on employers of 11 or more FTEs that fail to offer employees access to a "section 125 cafeteria plan" in accordance with the rules of the Commonwealth Health Insurance Connector Authority. We are currently reviewing 2008 Health Safety Net claims data to determine potential employer liability. Employers will be offered an opportunity to come into compliance with the Section 125 cafeteria plan requirement before a surcharge liability is issued.

Moreover, under Division regulations, employers must submit Employer HIRD forms detailing group health plans offered, contribution percentages, and whether they offer a "section 125 cafeteria plan." In addition, employers are required to have employees, who decline to enroll in an employer-sponsored health plan or participate in a Section 125 cafeteria plan, sign an Employee HIRD form indicating whether they have alternative insurance coverage. The Division has also designed a quarterly reporting mechanism for the HIRD to be reported directly to the Division. We will continue to work with our sister agencies to coordinate data collection efforts to minimize the administrative burden on employers.

More recently, in order to support financing of health care reform, Chapter 302 of the Acts of 2008 directed the Division to implement a $33 million assessment based on the net worth surplus available to health insurance carriers conducting business in Massachusetts. In consultation with the Division of Insurance, the Division has proposed regulations and recently held a public hearing. We are reviewing the testimony received and we anticipate a March 1, 2009 effective date for the regulation. This date will allow for collection of the assessment

amounts by June 30, 2009 as required by the statute.

In addition to these activities, the Division researches and publishes reports on the progress of health care reform, with special emphasis on access, quality, and cost. For example, since 1998, the Division has been responsible for conducting a biennial survey of health insurance coverage. The survey provides valuable information on both the Massachusetts uninsured and insured populations. We began conducting the survey annually in 2007 to monitor the impact of health care reform. In collaboration with the Urban Institute, the Division implemented a new and improved survey methodology in 2008 to reach the increasing sector of cell phone-only households. We plan to field the 2009 survey this spring.

I am pleased to report that the 2008 Massachusetts Health Insurance Survey found that over 97% of Massachusetts residents had health insurance coverage. Only 2.6% were found to be uninsured, the lowest rate of uninsurance in the country. Those most likely to be uninsured were non-elderly adults, Hispanic residents, and residents with family income less than 300% of the federal poverty level (FPL).

The Division also monitors the role of employers under health care reform. The data gathered through the Fair Share and Employer HIRD forms provide valuable insights into the availability and cost of workplace-based insurance. The Division also conducts a comprehensive annual survey of Massachusetts employers regarding their health insurance offerings. The findings from the 2007 survey reflected employer's continued support for workplace sponsored health insurance with nearly all employers with more than 50 employees offering coverage. In conjunction with the University of Massachusetts Boston Center for Survey Research, we will begin fielding the 2009 survey this month.

Section 304 of Chapter 149 of the Acts of 2004 requires the Executive Office of Health and Human Services (EOHHS) to produce an annual list of employers who have 50 or more employees using publicly subsidized health care each year. In collaboration with DOR, MassHealth, and the Connector, last year the Division has enhanced its methodology for the report. Results for FY 2008 will be released by April 1, 2009.

The Division releases a quarterly *Health Care in Massachusetts: Key Indicators* report, which provides an overview of the Massachusetts health care landscape through data reportedproviders, health plans, and government and through surveys of Massachusetts residents and employers. Theedition of the report, released in February 2009,that over 432,000 additional people have obtained health insurance since the implementation of health care reform.

Health Safety Net (HSN)

The Division is responsible for administering the Health Safety Net (HSN), which Chapter 58 created to replace the Uncompensated Care Pool (UCP). Like its

predecessor, the HSN makes payments to hospitals and community health centers for uncompensated care, and provides access to essential health care services for low-income Massachusetts residents who are ineligible for health insurance programs. The HSN also expanded the availability of medical hardship to provide the ultimate safety net for individuals who "fall through the cracks" in the health care system.

HSN policies reflect the following principles:

- Promotion of enrollment in health insurance coverage
- Consideration and alignment of policies with those of other state health programs (Commonwealth Care, Commonwealth Choice, and MassHeath)

Specifically, the Division works in collaboration with MassHealth to develop and implement improvements in the operations, management, payment processes, and data integrity of the Health Safety Net Trust Fund. For example, residents must apply for coverage through a common application process used by MassHealth, Commonwealth Care, and the Health Safety Net in order to ensure that individuals are enrolled in the most appropriate program. The Division and MassHealth continue to develop enhanced, coordinated eligibility operations to provide a seamless, single point of entry.

Similarly, the Division has worked closely with MassHealth to implement a claims-based Medicare type of payment system for hospitals and has increased payments to community health centers (CHCs) using the federally qualified health center (FQHC) medical visit rate. Ancillary services provided by CHCs are paid at MassHealth payment rates including all applicable rate enhancements. Moreover, the scope of HSN covered services is based on the MassHealth Standard benefit package, ensuring that the HSN leverages MassHealth's expertise and existing clinical policy decisions. In addition, all HSN claims for prescription medications are being processed through the MassHealth Pharmacy Online Payment System (POPS), providing a coordinated approach to coverage, prior authorization, payment, and pharmacy utilization review.

The agencies are also coordinating activities to monitor payments and claims trends, as well as partnering on HSN program integrity initiatives. These activities will permit the Division to ensure appropriate billing practices and eligibility determinations. Furthermore, the Division has leveraged an existing MassHealth partnership with a vendor to review paid claims on casualty recovery services. We have also signed a contract with the University of Massachusetts Medical School to review HSN paid claims with the goal of developing an appropriate and cost effective utilization review model. Lastly, the Division is in the process of securing an external vendor to conduct compliance audits on a subset of HSN providers to ensure compliance with HSN regulations.

We are committed to evaluating the impact of the new HSN eligibility and

coverage rules. The Division collects HSN patient claims from hospitals and community health centers. This information is used to monitor charges and utilization of service patterns within HSN, and to examine the demographic characteristics of individuals whose care is funded through the Health Safety Net. HSN volume for hospitals and community health centers declined by 36% in the first six months of HSN08 compared to the same period in the prior year of the UCP. Payments declined by 38% when comparing the entire 12 months of PFY07 and HSN08.

Chapter 302 of the Acts of 2008 required a $20 million increase in the assessment paid by hospitals into the Health Safety Net Trust Fund in HSN 2009 to be transferred to the Commonwealth Care Trust Fund. The Division adopted regulations and is currently collecting the additional funds.

The Governor's House 1 budget recommends $390M in total funding to the Health Safety Net Trust Fund in FY10. This funding projection is based on waiver assumptions and assumes no general fund contribution. In comparison to projected spending in FY10, the HSN should have an estimated nine million dollar surplus. Of course, all projections are subject to the realities of the economy and the subsequent impacts to the Health Safety Net. Current HSN trends, though, indicate a continuing decline in HSN payments and utilization as anticipated in the design of health care reform.

Purchase of Services (POS) Reform

The Division was also assigned new requirements related to standardizing rate setting methodologies for Purchase of Services (POS) programs according to service classes under "*An Act Relative to Rates for Human and Social Service Programs*" (Chapter 257 of the Acts of 2008). In order to perform these new functions, we are creating a POS unit, which will be responsible for:

- analyzing new FY09 pricing initiatives and POS pricing analyses;
- developing new rates and instituting a rate review process;
- holding regulatory hearings and inviting the public to testify on new rate methodologies; and
- accomplishing the outcome measures as defined in the statute:
    - Rates for 10% of POS contracts must be set by 10/1/09
    - Rates for 40% of POS contracts must be set by 10/1/10
    - Rates for 70% of POS contracts must be set by 10/1/11
    - Rates for 100% of POS contracts must be set by 10/1/12.

We are working closely with the EOHHS Purchase of Service Policy Office to implement these requirements.

Other Responsibilities

In addition to the FY 2009 priorities outlined above, the Division performs a number of other functions that are considered critical to the health care environment in the Commonwealth, including:

- analysis of cost, utilization, and acuity data to support pricing policy for public purchasers of health care services;
- management of the Qualifying Student Health Insurance Plan (QSHIP);
- implementation of the nursing facility user fee; and
- management of the Essential Community Provider Trust Fund.

The Division collects annual cost reports from hospitals, community health centers, nursing and rest homes, and ambulatory care providers. These data are used to support the health care pricing activities of the agency, as well as trend analyses of hospital costs, revenues, and utilization. We also collect and publish quarterly and annual financial reports from acute hospitals. This information permits the Division to monitor financial trends across the acute hospital industry and for individual hospitals. Lastly, patient-level data for acute hospital inpatients, observation patients and emergency room patients are collected to support the Division's analyses of such issues as preventable hospitalizations, hospital market analysis, alternative care settings, the patient care continuum, and comparative costs and outcomes in acute care hospitals.

In accordance with Massachusetts General Law Chapter 118G, the Division sets rates of payment for governmental entities for client services provided by nursing facilities, community health centers, home health agencies, independent practitioners, and other health care providers. MassHealth is the largest state-run program for which the Division sets payment rates. In addition, the Division sets rates that may be paid by private sector payers such as non-contracting industrial accident payers and the maximum rates that may be charged by temporary nursing agencies to hospitals and nursing facilities. The Division is responsible for promulgating pricing regulations for approximately 40 different types of health care providers. Our objective is to set rates of payment that support the procurement of quality health care services in the most efficient manner possible. To date in FY09, the Division has promulgated 14 regulatory amendments and we expect to hold public hearings and promulgate 8 additional regulatory amendments by the end of the current fiscal year.

The Division administers the Qualifying Student Health Insurance Program (QSHIP), which establishes minimum health benefit standards for students and ensures compliance with the student health insurance requirement. In FY09, we have undertaken efforts to conduct a comprehensive review of the regulations governing QSHIP. This review includes an actuarial analysis of existing QSHIP plan benefit levels and a comparison to other market products. The Division will soon release a proposed regulation that will greatly improve the data available to understand QSHIP health insurance programs.

Moreover, the Division administers the nursing facility user fee program, which requires nursing facilities to pay $145 million per year to the Commonwealth in the form of a per-day fee assessed on all non-Medicare resident days. Funds generated by this program are eligible for federal matching funds and are used to

supplement MassHealth payments to nursing facilities. Due to continued declines in nursing facility utilization, the Division increased the user fee last July. For most facilities, the current fee is $11.45 per non-Medicare bed day. Facilities that are part of a continuing care retirement community and certain large non-profit facilities that participate in the Medicaid program are assessed a fee of $1.15 per non-Medicare day. A small number of facilities that do not participate in the Medicare or Medicaid programs are exempt from the fee entirely. Overall, facility compliance with payments to the Division for this assessment has been excellent. We continually monitor the fee amount to ensure that it is set at an appropriate level to generate the required $145 million in revenues. The FY 2010 budget proposes to increase the assessment by $75 million (increasing the total aggregate assessment to $220 million) which will be directed to maintain current nursing facility rates, fund a small rate increase, and fund performance-based incentive payments.

Administration

Finally, I would like to comment on the Division's FY 2010 funding appropriation. House 1 recommends an FY10 appropriation of $17,449,078, which will help support both the Division's existing initiatives and new statutory responsibilities.

The Division is funded by assessments on acute hospitals and Federal Financial Participation revenue for administrative expenses related to our work to support administration of the MassHealth program. In FY 2008, the Division generated $17,826,086 in revenue. We anticipate generating $20,655,254 in revenue in FY 2009 and approximately $20,249,582 in FY 2010 assuming an appropriation equal to the House 1 recommendation.

I appreciate this opportunity to discuss the Division's responsibilities and ongoing initiatives. We are committed to ensuring the availability of relevant health care system data to meet the needs of policymakers, health care purchasers, providers, and consumers. I welcome any suggestions you may have for additional research or analyses that should be undertaken by the Division, and I am happy to answer any questions. Thank you.

EXECUTIVE OFFICE OF ELDER AFFAIRS

Good morning Senator Hart, Representative Fox and members of the Committee. Thank you for this opportunity to testify. I enthusiastically embrace this opportunity to discuss and advance the agenda for the Executive Office of Elder Affairs.

Our mission at Elder Affairs is to promote the independence and well-being of individuals, their families, and caregivers through the development and delivery of quality services; to provide consumers with access to a full array of health and social support services in the settings of their choice; to inform consumers about all their long term care options; to deliver elder protective and advocacy services; and to encourage behaviors that will lead to healthy aging.

Our on-going success in this mission is reliant on the Administration's unwavering support of the principle of Community First, and the extraordinary work of a strong and diverse network of local service providers that offer a continuum of community- based options including housing with supports, nursing facility diversion, and health and safety programs.

Despite the current fiscal climate, our budget signifies a strong commitment of support to Massachusetts' elders having the option to safely age with dignity in the communities which they helped to build.

It is first necessary to acknowledge that Fiscal Year 2009 has been a year of extremely difficult decisions. In all major program areas we have implemented cuts to degrees that were not reasonably contemplated at this time last year. I wish to emphasize that in every instance, we carefully and seriously evaluated each service reduction before any action was taken. Our strategy when considering the FY09 reductions was to anticipate an economic downturn continuing over an eighteen month period. Our goal was to implement cuts that, if necessary, could seamlessly transition into FY10. Our hope was this thoughtful process would spare those we serve from several rounds of one-time cuts. The process was collaborative across EOHHS., including working closely with our colleagues in the Medicaid agency. Our proposed H1 FY2010 budget illustrates the success of this strategy. The Executive Office of Elder Affairs' is well-positioned to advance its mission and deliver highly effective services in FY2010.

As Director Dehner testified, our FY10 budget consolidates many of the MassHealth accounts. In addition, the budgetary authority for the Senior Care account is moving to MassHealth.This move in no way changes the way long term care programs will be budgeted. MassHealth, Elder Affairs and the Division of Health Care Finance and Policy have always worked together to develop the budget for the long term care programs and we will continue to do so in

FY10.This account consolidation will not negatively impact programs and Elder Affairs will remain fully involved in the management of long term care programs.

As an example of the approach made, for FY09 our State Home Care Program is now operating at 9% below FY08 funding levels. This reduction has had a significant impact, most visibly with the establishment of waitlists in our “Basic” program. However the implementation of this waitlist includes a carefully considered triage protocol, allowing us to ensure the enrollment of clients most in need of services. Furthermore, when potential Basic clients are on a waitlist for Home Care services, we are leveraging federal funds to offer home delivered meals to such clients. Finally, when potential clients are placed on the waitlist, they are contacted every 30 days by a case manager to check on their condition to determine if there has been a change. Although we regret that we are in a position of having to maintain a waitlist, we are pleased to report that due to the mitigation efforts on the part of EOEA and our network, at no point this year will we have to entirely freeze enrollment into the Basic program.

Our FY10 proposal funds the Home Care Program at 2% over FY09 post-9c funding levels. Although this increase may not allow us to fully alleviate the need for waiting lists, it will limit the list to less than 1% of monthly capacity (or about 300 people). Furthermore, our experience in managing the FY 2009 downturn has demonstrated the need for funding flexibility between the Home Care accounts. This need for greater flexibility is contemplated in FY2010 by consolidating the Home Care Basic, Home Care Case Management, Enhanced Home Care (ECOP), and Nutrition accounts. Consequently EOEA will be well positioned to manage and serve the maximum amount of seniors in the programs that best meet their individual needs. See Appendix section I.

I am proud to note that in our FY10 proposal, we fully preserve the Community Choices program which, funded by state and federal Medicaid dollars, allows us to support in the community more than 5,000 elders who would otherwise be eligible for nursing facility services.

The FY2009 budget included over $57.5 million to fund Prescription Advantage. However, early FY09 projections suggested the actual costs of running the program were in the neighborhood of $61.6M. With the Prescription Advantage program forecasting a significant deficiency, and our FY2010 projections suggesting a funding need of $63M., we grimly set upon the task of redesigning the Prescription Advantage benefit. Our goal was to maximize the relief we could offer seniors in drug purchasing assistance by working to supplement the Medicare Part D benefit, the commonly referred to “donut hole”, with state funding. Understanding the considerable burden this coverage gap can place on a senior’s household without additional supplement, another goal of redesign was to ensure no Prescription Advantage member would lose state supplemental coverage completely.

For members in categories S2-S5, assistance now begins in the Medicare Part D coverage gap, defined as the point in time when the total retail cost of drugs covered by a Medicare Part D plan reaches $2,700 for calendar year. Prescription Advantage will continue to pay all or part of the Medicare Part D plan's monthly premium for members who have received premium assistance in the past and remain in the same income category. Our FY10 budget of $45M fully supports the redesign, continuous enrollment of new members, and aggressive outreach to make beneficiaries aware of the benefit change. See Appendix section III.

In FY09 the Elder Protective Service Program received an increase of $1.2M over the previous year. These funds were used to address the growing problem of elder abuse and the resulting increased caseloads in our protective services agencies. In addition, in partnership with the Attorney General and District Attorneys we have begun an extensive campaign to educate and cross-train professionals on the needs of the elderly population with a particular focus on elder abuse prevention and detection. The goal of these collaborations is to provide public and private sector professionals with the training and skills necessary to maintain and improve the safety net for the protection of vulnerable elders.

Our budget in FY10 maintains our commitment to this vulnerable population and we will continue to leverage the partnerships we have forged in order to expand capacity of protective services for elders even during these tough fiscal times. See Appendix section II.

Councils on Aging (COA's) continue to be an essential part of the continuum of care, offering a variety of services and programs to elders living in the community. COAs maintain their strong community connection to seniors by providing meals to local elders, assisting with transportation, and offering volunteer opportunities and counseling services. In addition they offer activities that help reduce social isolation, enhance social and civic engagement, foster independence and promote healthy lifestyles. The initial 2009 budget would have increased the formula grant amount per elder from $6.50 to $7.00. However, during the January 9c process, the line was reduced to the FY08 level of $6.50 per elder. This reduction was with a "one-time" perspective, as our FY10 budget restores the $7.00 per elder number for the upcoming fiscal year to each Council on Aging. See Appendix section IV.

In recognition of time and with your consent, I wish to offer the committee the balance of my testimony in writing at this point. You will find additional program detail and other budget information that I hope will be of interest to you.

In closing, I would like to reiterate my strong commitment to improving the quality, capacity and delivery of the programs and services we offer to elders and

their families. Thank you for the opportunity to testify today and I look forward to working with you on behalf of the elders of Massachusetts. I'll be happy to take questions at this time.

Appendix to Testimony

I. Home Care, Enhanced Home Care, Case Management and Nutrition

Administered through our Aging Services Access Points (ASAPs), Home Care continues to be a cornerstone in the continuum of care and integral to the success of our community first mission. In the first7 months ofyear(July 2008-January 2009), an average of 45,642 clients per month were served.Among them,,598in the state home care program,4,890the Enhanced Community Options,,100in the Community Choices Program, and 54 inCaring Homes Program.-six percenthome care clients, or,897, are nursing facility eligible but stay at home with services from these programs.

In order to more efficiently manage the Home Care accounts our budget consolidates Purchase of Services Homecare Services (9110-1550) – funded at $199,176,025. The build up to this number includes $105.8M for Home Care Purchase of Service (HC POS), $47.7M for Enhanced Community Options Purchase of Service, $38.6M for Home Care case management (HC CM) and $6.3M for Nutrition Elder Lunch. HC POS is funded $3.3M above the FY09 post 9c level and HC CM is funded $1.1M above the post 9c level. These increases make up a 2.2% total increase over FY09 post 9c in this consolidated account. Consolidating these accounts allows us to best the most people including serve those with the highest level of need.

The FY09 Home Care line was readjusted based on a 9C reduction of approximately $6.8 million. As part of our 9c mitigation plan, we directed the use of one time dollars held at the ASAP level to be spent on purchasing home care services for elders who would otherwise end up on the programs waitlist. Despite these efforts we still maintain a waitlist of several hundred and that list is expected to reach 600-800 by July 1. Additionally, increased the cost sharing required of seniors enrolled in the Home Care and ECOP programs by an average of 25%. 27, 378 clients will see an increase in their out of pocket costs.

Our budget proposes maintenance funding for the Protective Services Program, which is essential to ensuring that our most vulnerable elders are protected.order to enhance this already robust Program so that it reaches more elders at the point of prevention rather than intervention we are collaborating with the Attorney General's Office, District Attorneys, Bar Associations and others to put a greater emphasis on outreach, education and prevention. For example, we will partner with local Bar Associations to enlist more attorneys to work on a pro bono basis on guardianship and conservativeship cases, thereby bringing more resources to support the work of the Protective Services Program. Protecting elders from abuse and preventing harm to our vulnerable populations is an issue of utmost importance.

II. Protective Services

Maintenance projections for the Protective Service Program are 5% above FY09 spending levels. This increase is due to the projected 5.3% increase in reports of abuse from FY09-FY10. In order to address this increase in caseload and the un-served abused elder population, Elder Affairs will need to increase the number of Protective Services caseworkers funded in the system. This will ensure that caseloads are kept at, or slightly below our maximum monthly caseload standard of 21 cases per caseworker.

III. Prescription Advantage

FY10 maintenance for the Prescription Advantage program is 11% less than projected FY09 spending. This reduction is the result of the significant 1/1/09 program redesign, eliminating benefits with the exception of the "donut hole" period of Medicare D coverage.

FY10 will be the first state fiscal year where we will experience twelve months of the program redesign; as such, maintenance for the program is considerably lower than the FY09 spending estimate.

IV. Councils on Aging

While each COA is unique to its community, most Councils utilize their formula grant funds to offer information and referral, transportation, outreach, meals (congregate and home delivered), health screening, and fitness and recreation programs. Our FY10 budget also includes $700K towards Service Incentive Grants (SIG). The SIG is a small but important competitive grant that supports local COA policy initiatives such as transportation consortiums and volunteer coordination.

V. Housing

EOEA manages three housing programs, Supportive Housing, Congregate Housing and Residential Placement for Homeless Elders. Our FY10 budget proposal for the three Elder Housing accounts calls for the consolidation of the accounts each at the FY09 post 9c level. Through the consolidation these three accounts EOEA will be to maximize housing with supports opportunities for the elderly and disable of the Commonwealth.

Please note that throughout this budgetary cycle, we hope to bring focus to a historical earmark associated to the Congregate Housing program that we hope to align with the Supportive Housing program. Doolan Apartments operates as a supportive housing program funded through an earmark in the Congregate line item. This housing program is viewed by ELD as the 32nd site in our Supportive Housing program.

DEPARTMENT OF VETERANS' SERVICES

This administration has had to make a number of hard choices over the last several months in the hopes of securing our economic future. This has been a difficult time for many in the commonwealth. Due to the economic environment, the Department of Veterans' services is seeing an increasing number of veterans in need of financial assistance. This administration has kept benefits to our veteran and families intact. The Veterans' Service Officers throughout the state realize the commitment our state government, at its highest levels, has to its veterans and servicemembers. House one recognizes the increased demand for services and provides the necessary funding. Through the Governor's Advisory Council on Veterans Services, this administration showed its staunch support of the veteran community as a whole. We are all truly grateful for this continued cooperation.

The consolidation of our line item accounts from ten to five allows for increased flexibility at the department and secretariat levels allowing us to better service an ever- broadening scope of veterans and family members. The current Chapter 115 case load currently stands in excess of 5000 cases. This is a 40% increase since 1999. These are veterans that live in your communities. They are widows and elderly, some have families and others are single parents or individuals living in shelters or transitional residences.

We have continued our outreach efforts over the past year. We partnered with DPH in two distinct programs, one being a smoking cessation program which has assisted 1,382 veterans or family members that are trying to quit. DPH is receiving an average of 15 calls per day. This program is scheduled to end on June 30, 2009. The other is our SAVE (Statewide Advocacy for Veterans' Empowerment) team with their main focus being suicide prevention. In its one year of operation, this group has had direct contact with over 635 veterans, of whom 415 have had potential suicide issues, PTSD, and TBI assessments administered to them. The Save team currently has an active case load of 137 and has made referrals to 88 individuals. This is in addition to the team's constant involvement with job fairs, campus events, and mental health syposiums.

We are also working with DTA in order to continue our efforts to increase participation and maximize SNAP benefits for indigent veterans on C.115 veterans' benefits program.

DVS continues to partner with MA EOL/DWD, Division of Career Services, on the US Department of Labor/Veterans' Employment and Training Services (DOL/VETS), Veterans' Workforce Investment Program (VWIP)which provides outreach, training opportunities, job readiness, and assistance infindingthe priority of servicetargeted--those recently separated, OEF/OIF veterans, veterans with disabilities, and those with significant barriers to employment.DVS along

with other veteran serviceincluding VSO's have made strides in enhancing existing partnershipsthe One-Stop Career Centers by co-sponsoringOne-Stop Veterans' Representatives Conference September 2008, along with the open invitationall city/town VSOs.

We have continued to mail our “Welcome Home” guide to those returning services members to educate them on benefits and services they have earned and have mailed out 3,000 this year alone.

Our commitment to veterans has not lessened we just have to redirect our focus to working with veterans’ service officers and legislator to create the most efficient programs possible in these uncertain economic times.

THE SOLDIER'S HOME IN HOLYOKE

The Soldiers' Home in Holyoke is proud of its accomplishments over the course of this past year. We have maintained an occupancy rate of 98% in our long-term care unit and 93% in our dormitory.

What this has meant for the Commonwealth of Massachusetts is a return on its investment in the Soldiers' Home in Holyoke of 57%. Simply stated for every $1.00 appropriated, we return 57 cents.

Approximately two thousand one hundred fifty (2,150) veterans visited the outpatient clinics over the last fiscal year. Such services as urology, cardiology and hematology, among others, were provided to these community-based veterans.

Dental visits to the outpatient dental clinic totaled just over two thousand (2,000) for the same period. Three thousand six hundred (3,600) prescriptions were filled during the same period by the outpatient pharmacy.

The Home's pharmacy has been managed by the State Office of Pharmacy Services. We have had a competent staff who has assisted in helping to reduce medication errors by over 50%, with the advent of blistering packaging and clinical drug reviews.

Our hospice unit continues to be praised by surviving spouses and community visitors for the tasks they perform at our veteran's end-of-life care.

The asbestos removal/air-conditioning project is 98% complete and our veterans are provided a facility with full air-conditioning, well-lit rooms and hallways, and a bright home-like atmosphere.

House 1 results in the loss of valued services in the outpatient dental clinics. Partnerships with private dental clinics and public clinics, as exist at STCC, are being explored.

Lay-offs of personnel are a reality, but there will be no direct effect on the long-term care being provided to our veterans.

FY10 Financial Points:

- H.1 results in a reduction to FY10 Maintenance of $879,123
- While the reduced funding will impact indirect care staff, there will be minimal impacts to direct patient care.
- FY10 operational revenue is projected to exceed FY09 projections by 3.6% or $426,882.

THE SOLDIERS' HOME IN CHELSEA

Thank you giving me the opportunity to appear before this committee and provide you with some information about the Soldiers' Home. My name is Michael Resca. I am the Commandant (the agency head) of the Soldiers Home and I consider it an honor and privilege to continue the Commonwealth's long tradition of providing quality care to our veterans.

Organizational Mission:
The Soldiers' Home in Massachusetts is a state-funded agency under the auspices of Executive Office of Health and Human Services. It is defined by Chapter 115A of Massachusetts General Laws, with the mission to provide comprehensive health care, housing, and human services for all eligible veterans.

Eligibility:

Qualified veterans as defined by Massachusetts General Laws requires that the applicant to be a legal resident of Massachusetts, received an honorable military discharge, served in the armed forces of the Unites States for at least 90 consecutive days during war time periods or at least 180 consecutive days during peace time periods.

Philosophy

Health care is provided primarily for non-war related injuries and other medical problems. Housing is given to all in need. Our designated service area includes all but the four most western counties of the Commonwealth.

The Soldiers' Home in Massachusetts is committed to assisting our veteran clients to attain the highest possible level of health and well-being. Our aim is to give every veteran the finest and most comprehensive care necessary to prevent disease and to preserve health. If we are unable to render the necessary treatment, housing, or services required by our veterans, we will seek available resources and arrange for the prompt and safe transfer of our clients.

We believe that each human being is a unique individual; we believe in the dignity and value of human life and in the individualized physical, mental and spiritual needs of all our clients; we believe that all individuals have rights that must be respected. We promote active individual and, when appropriate, family participation in the formulation, implementation, maintenance, modification and evaluation of the plan for care from admission to discharge. We recognize and respect the unique psychosocial, spiritual and cultural needs of our veterans and their families at the end of life by providing comfort, dignity and responsive care as desired by the veteran.

The Long Term Care service has a capacity of 174 beds and operates at a 95% plus occupancy. The waiting list remains constant. As beds become vacant, they filled within 48 hours. While we have existing space to accommodate an additional 16 beds unit, funding is not available.

Dorm Services has a capacity of 305 beds and has seen a dramatic increase in the census of veterans from the Persian Gulf and peace time eras. While we currently house 286 veterans in our dorms: 54 are from WWII and Korea, 175 are Vietnam veterans and 56 are veterans from the Persian Gulf, Iraq and peace time eras. Disability pensions are received by 201 residents in the dorm. Two hundred and one dorm residents have been admitted from the homeless environment.

All of our services support and complement the Governor's priorities of ending homelessness, reducing hunger and encouraging nutritional health, promoting public health and wellness and disease prevention as well as delivering high quality disability services.

We are blessed with an active group of volunteers at our facility. We also have an active Family Council and a residents Council at the Soldier's Home. We are also supported by the many and various local social, fraternal and veteran's organizations in our service area. Organizations such as the American Legions, Amvets, Elks, Disabled American Veterans, VFW, and Jewish American War Veterans support our mission and volunteer their time for the comfort of the veterans under our care.

Facilities:

The Chelsea Soldiers' Home is comprised of approximately a half a million square feet of space in eleven (11) buildings located on sixteen (16) acres of land. In addition to the buildings, the Chelsea Soldiers' Home maintains historic Malone Park located at the summit of Powderhorn Hill (where George Washington camped with his troops as they overlooked Boston Harbor).

All buildings are state owned and located at 91 Crest Avenue, Chelsea, Ma.

Budget:

The FY2009 funding was strictly a level funding maintenance budget at $26,968,587. Salaries and fringes accounted for $20.2 mil, Utilities at $1.8 mil, Pharmacy Services at $1 mil, Dietary at $1.1 mil, Clinical Services at $1.9 mil with Maintenance, repairs and all other expenses at $855,000.

The FY 2009 budget mandated that we transfer all pharmacy operations to the State Office of Pharmacy Services. That transition was completed effective

January 1, 2009. The change in pharmacy providers left us with an unfunded expense for six months of approximately $360,000 in FY 2009 and potentially $720,000 for FY 2010 which we have been required to absorb.

As a result of the FY 2009 FTE and staffing caps implemented (based on July 3, 2007 payroll) we were required to cut 17 FTE's from our original budget funding. The Soldiers' Home limited and restricted back filling of positions when they became vacant.

While the Soldiers' Home was spared from the 9C cuts implemented in October 2008, we currently implementing staff reductions (layoffs) and reducing services in our outpatient clinics to implement the latest FY 2009 9C mandated cuts, cover the unfunded pharmacy costs as well as to meet our FY 2010 budget cap.

Our budget appropriation request for FY 2010 in House 1 is $25,264,000 for operations (which is $1.7 mil or 6.4% less that FY 2009) followed by our Retained Revenue / license plate appropriation of $300,661.

In our budget submissions to the Ways & Means Committees we outlined how we would cope with additional cuts of 10% and 15% as was requested. Our main priority is operating and maintaining beds in our long term care and domiciliary services. Implementing further cuts while preserving beds would require us to further reduce or eliminate all outpatient clinical services and/or permanently close our School of Practical Nursing. We realize these reductions and closures would likely be permanent.

Current Staffing:

The Chelsea Soldiers' Home was capped for 389 FTE's for FY 2009. Direct Nursing Care has 170 FTE's, Clinical support services has 46 FTE's; Dietary has 58 FTE's; Housekeeping has 44 FTE's and the balance of 71 FTE's covers Security, Medical Records, Maintenance, Transportation and other administrative services.

Limiting our ability to back fill direct patient care positions has forced us to increase paid overtime in order to meet minimum staffing and safety levels in our long term care service.

There will be a further reduction in FTE's in preparation for FY 2010 resulting from layoffs (currently underway), retirements and normal attrition.

Hiring will be severely limited to back filling turnover in direct patient care positions or critical support positions.

There are no significant hires anticipated for FY 2010.

Revenue:

During FY 2010 the Soldiers' Home is budgeted to generate revenue of $12,265,000, which is approximately 47% of our appropriation. The Department of Veterans Affairs (Federal) provides the single largest portion of our revenue, over half, in the form of a per diem of $71.42 for nursing care and $33.01 for the domiciliary. Changes in VA rates are usually effective October 1.

Our resident veterans pay a daily care charge of $30 per day for nursing care and $10 per day for the domiciliary. The daily care charge is currently under review.

Medicare and other third-party insurances reimburse us for some of health care services provided.

Accomplishments:

- The Soldiers' Home was successful in being surveyed by the Joint Commission for Accrediting Healthcare Organizations during October 2008.
- The Soldiers' Home has been inspected annually by the Veterans' Administration and the Department of Public Health.
- Residential Services Program has been completely reorganized. The Continuing Care Coordinator role has been expanded to include residential veteran placement.
- The admission process has been streamlined, as an interdisciplinary approach /clinical care model was adopted which allows a greater number of homeless veterans from the local shelter being accepted for admission.
- Successfully implemented an assisted living program allowing older vets to stay in dorm settings longer, retain independent living and delaying them from entering the long term care / skilled nursing facilities.
- A partnership with the VA has been expanded. Mental Health Intense Case Management clients have been accepted. Cooperative collaboration between the VA and Chelsea staff has allowed for the management of more complicated psychiatric cases. A cooperative alliance has also been well underway between the Bedford VA Bridges Program with an onsite social worker and liaison to the Bedford VA psychiatric services.
- A partnership with the VA has been expanded. Mental Health Intense Case Management clients have been accepted. Cooperative collaboration between the VA and Chelsea staff has allowed for the management of more complicated psychiatric cases. A cooperative alliance has also been well underway between the Bedford VA Bridges Program with an onsite social worker and liaison to the Bedford VA psychiatric services.
- A partnership has been established with the UMASS Certified Addictions

Counseling program. Interns are providing one to one counseling and group therapy for a full semester each carrying a full case load under the supervision of our licensed addiction specialist.

- We are active participants in the Veterans Services Committee established by Governor Patrick and chaired by LT Governor Tim Murray.
- We are a partner with DCAM and Mass Development in a project to install photovoltaic (solar cells) capable of generating over 60 kW of electricity using grant funds and CREB (clean renewable energy bonds) funding. Installation expected to be completed before the end of the summer of 2009.
- Responding to the increase in the women veteran population, we have pending plans to expand, as needed, the Women's Veterans Wing in Dorm Buildings.
- An independent review of the School of Practical Nursing was commissioned by Secretary Bigby to measure value and effectiveness of this educational program. The final report, when issued, is expected to provide some guidance and direction regarding the future of the school.

Challenges:

- Upkeep of our existing building and physical plant is a MAJOR challenge as our newest building was constructed in 1952 while our oldest building was constructed in 1882.
- Maintaining current level of beds and clinical services given the current financial constraints.
- Maintaining the facility to comply with standards established by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), Department of Public Health (DPH), as well as the Veterans Administration (VA) continues as an ongoing struggle.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

FY10 BUDGET HEARING BEFORE THE JOINT COMMITTEE ON WAYS AND MEANS

Roxbury Community College
Media Arts Center
1234 Columbus Ave.
Boston, MA 02120

Wednesday, March 4, 2009